

Central Park Dental Group

Patient Information

Today's Date _____

Patient Name: _____ Parent's name if minor _____
Last First (Preferred)

Birth date: ____/____/____ SS#: ____ - ____ - ____ Driver's Lic or Other ID: _____ Marital Status: _____

Address: _____ E-mail: _____
Street Apt City State Zip Code

Home Ph: (time to call): () _____ Work Ph: () _____ Cell Ph: () _____

Employer Name and address: _____
Employer Street Suite City State Zip Code

Person to notify in case of emergency: _____ Relationship _____ Phone: _____

Financial Policy

ON FEES AND PAYMENTS:

Payment is expected at the time of service. Fees are subject to change with prior notice before treatment. Balances remaining beyond 30 days from billing will have a late payment charge of \$20 and accrue a monthly interest at a rate of 10% APR. There is a \$35 processing fee for returned checks, and a \$50 per hour fee for broken appointments without 48-hour notice. Co-payment is expected at the time of service.

ON DENTAL INSURANCE:

We accept most PPO dental insurances. The insurance policy is an agreement between you (the patient, or patient's employer), and the insurance company, not between the insurance company and this office. It is the patient's responsibility to understand his/her insurance policy prior to treatment. Insurance benefits are subject to change based on condition of employment, change in benefit coverage or non-coverage, or change in patient status. If your insurance pays for an alternate benefit, you will be responsible for the difference between the fee for the actual procedure and the alternate procedure fee. If your insurance does not pay in full for any reason, you will be responsible for the remaining balance of the treatment.

I take responsibility for payment of all services rendered on my behalf or my dependents regardless of any insurance involvement. In the event of default, I promise to pay legal interest on the indebtedness, collection costs, and related legal fees.

Signature of Patient / Guarantor if minor

Date

Assignment of Benefits and Authorization Release

I hereby authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. If my current policy prohibits direct payment to doctor, I hereby also instruct and direct my insurance carrier to make out the check to me and mail as follows:

Central Park Dental Group, 2660 Homestead Rd. Santa Clara, CA 95051

I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, and for any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf. A photocopy of this Assignment shall be considered as effective and valid as the original.

Signature of Patient / Guarantor if minor

Date

Dental History

Date of last dental visit :	Services performed:	Date of last full mouth x-rays:
Please check all that applies: <ul style="list-style-type: none"><input type="checkbox"/> Bleeding gums<input type="checkbox"/> Sensitive teeth<input type="checkbox"/> Toothache<input type="checkbox"/> Wisdom teeth removal<input type="checkbox"/> Dental Surgery<input type="checkbox"/> Dental complications<input type="checkbox"/> Wearing (please circle) denture mouth guard retainers	Dental products used: <ul style="list-style-type: none"><input type="checkbox"/> Power toothbrush _____<input type="checkbox"/> Floss<input type="checkbox"/> Perioaid/ gum stimulator<input type="checkbox"/> Proxy brush<input type="checkbox"/> Mouth rinse _____	Please check if interested: <ul style="list-style-type: none"><input type="checkbox"/> Whitening teeth<input type="checkbox"/> Straightening teeth<input type="checkbox"/> Dental Implants<input type="checkbox"/> Cosmetic dentistry
Please describe any current dental problem		

